State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number and Street, City and Zip)
2a. Phone Number
3 .LOCATION (if different from Mailing Address (Number, Street, City and Zip)
3a.Location Code
4. NATURE OF BUSINESS; eg. Painting contractor, wholesale grocer, sawmill,hotel,etc.
5. State unemployment insurance acct. no.
6. Type of Employer: Private, State, City, County School Dist. Other Govt

INJURY

7. DATE OF INJURY / ONSET OF ILLNESS
8.TIMEI NJURY /ILLNESS OCCURRED
9. TIME EMPLOYEE BEGAN WORK;
10.IF EMPLOYEE DIED, DATE OF DEATH
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY?
12. DATE LAST WORKED:
13. DATE RETURNED TO WORK
14. IF STILL OFF WORK, CHECK THIS BOX:
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY? Yes:
16. SALARY BEING CONTINUED? Yes: No:
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS:
18.DATE EMPLOYEE WAS PROVIDED CLAIM FORM:
19. SPECIFIC INJURY/ILNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, eg. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

ORIGINAL

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? YES NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, eg. Shipping department, machine shop.
23. Other Workers Injured/Ill in this event? Yes No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, eg. Acetylene, welding torch, farm tractor, scaffold:
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OCCURRED , ef. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, eg. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

ILLNESS

27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip)
27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? No___ Yes ___then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip).
28a. Phone Number
29. Employee treated in Emergency Room? Yes

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2. *

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURIY NUMBER
32. DATE OF BIRTH
33. HOME ADDRESS (Number,and Street, City, Zip)
33a. PHONE NUMBER
34. SEX: MALE FEMALE
35. OCCUPATION (Regular job titile, NO initials, abbreviations or numbers)
36. DATE OF HIRE:
37. EMPLOYEE USUALLY WORKS (hours per day, days per week, total weekly hours)
37a. EMPLOYMENT STATUS (permanent, temporary, part-time or seasonal)
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38.GROSS WAGES/SALARY PER
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No

Please do not use this column

CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Completed By (type or print)	Signautre & Title	Date

*Confidential information may be disclosed to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim: and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.